CPT ADVISOR

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Clinical evaluation of suspected deep vein thrombosis guides the decision to anticoagulate prophylactically but does not impact the decision to perform after hours duplex venous scanning or increase its yield

The combined CPT and American Medical Association/Specialty Society Relative Value Scale Update Committee (or RUC) Five-Year Review Identification Workgroup screened CPT codes billed together 75% or more of the time. From this assessment, the workgroup indicated that there was duplication of work among CPT code 37201 (*Transcatheter therapy, infusion for thrombolysis other than coronary*) and CPT code 75896 (*Transcatheter therapy, infusion, any method [eg, thrombolysis other than coronary], radiological supervision and interpretation*). Therefore, a set of four bundled CPT codes were created under the direction of radiology, cardiology, and vascular surgery. The societies recognized that these patients require a significant amount of evaluation and management work typically in the intensive care unit during multiday infusions and therefore included such work in the code creation process. These new descriptions became valid in 2013 accompanied by simultaneous deletion of the CPT code 37201 and exclusion of code 75896 for use with thrombolysis. Additionally, the associated reimbursement was revalued in the facility setting through the RUC survey process using a 0-day global period as assigned by the Centers for Medicare and Medicaid Services.

It is important to note the difference between injection and infusion as defined in the CPT manual. The CPT codes for thrombolysis necessitate an actual prolonged infusion by pump of the agent in an area outside the angiography suite. Instilling a thrombolytic drug through a catheter as a bolus by hand is termed "injection" (no matter how slowly it is administered) and is not separately reimbursable.

The new codes distinguish the initiation, continuation, and cessation of thrombolytic therapy in the arterial and venous vascular beds. The work required for the thrombolytic infusion will depend on the vessel catheterization and, thus, coding for the procedure will require separate vascular catheterization codes in addition to the arterial or venous thrombolysis infusion code. This reflects current coding practice and more accurately reflects the highly variable work required for thrombolysis of different vessels. In addition, other services may occur at the time of infusion and remain separately reportable. These include mechanical thrombectomy before and/or after infusion, additional endovascular therapeutic interventions along with their associated radiologic supervision and interpretation as required (ie, angioplasty, stent, atherectomy), intravascular ultrasound, diagnostic angiography documenting runoff vessels or vessel patency (if no previous imaging exists and a full study is performed), and inferior vena cava filter placement, repositioning, or removal. Services that are not separately reportable include moderate/conscious sedation, nonselective catheter repositioning, follow-up angiography through the existing catheter during therapy, exchange of previous placed catheters during thrombolytic therapy, and all ongoing evaluation and management services, excluding the initial evaluation at the time of starting the therapy.

CPT code 37211 denotes "*transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiologic supervision and interpretation on the initial treatment day*"; CPT code 37212 describes "*transcatheter therapy, venous infusion for thrombolysis, any method, including radiologic supervision and interpretation on the initial treatment day*"; CPT code 37213 designates "*transcatheter therapy, arterial or venous infusion, for thrombolysis other than coronary, any method, including radiologic supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including the follow-up catheter contrast injection, position change or exchange when performed*"; and CPT code 37214 defines "*transcatheter therapy, arterial or venous infusion, for*

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thrombolysis other than coronary, any method, including radiologic supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including the follow-up catheter contrast injection, position change or exchange when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method."

CPT codes 37211-37214 can only be reported once per date of treatment. The day is defined as midnight to midnight. All return trips to the angiography suite for follow-up imaging through the catheter and/or catheter exchange are bundled on a given day of therapy. CPT codes 37211 and 37212 describe the initial day for institution of the infusion. Only one of the codes is reported based on the treatment being arterial or venous. Therefore, if initiation and termination of thrombolytic therapy occurs on the same calendar day, then either CPT code 37211 (arterial) or 37212 (venous) would be reported once regardless of the number of trips to the interventional suite. CPT code 37213 describes a day of treatment whereby the patient had the infusion running on the previous day and that thrombolytic infusion will continue through at least the following calendar day. CPT code 37214 requires that the infusion occurred on the prior calendar day but terminates on that day. A 2-day course of therapy involves initiation of treatment with either CPT code 37211 (arterial) or 37212 (venous) on the first day and CPT code 37214 on the second day. A 3-day course of therapy would have either CPT code 37211 (arterial) or 37212 (venous) on the first day, CPT code 37213 reported on the second day, and CPT code 37214 on the third day.

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